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Health Care Affordability Board
November 20, 2024
Public Comment

The following table reflects written public comments that were sent to the Office of Health Care Affordability email inbox.

Date	Name	Written Comment
11/21/2024	Hemophilia Council of California and Rare Disease Access Coalition	See Attachment #1. I am submitting the attached comments on behalf of my client, the Hemophilia Council of California, and the Rare Disease Access Coalition regarding the proposed Quality and Equity Measurement Set, as detailed in the November OHCA Board meeting. We are hopeful that OHCA will design and implement policies for persons living with a rare disease by including rare disease patient access to diagnostics and treatments, while promoting strategies to shorten the diagnostic journey in their proposed quality metrics. By failing to include rare disease patients in the proposed measurement set, OHCA is missing an opportunity to explore options to reduce spending growth in this patient population by shortening the diagnostic journey and delays to specialized treatments. Should you have any questions regarding these comments please feel free to contact me, or in the alternative, my client, Lynne Kinst, Executive Director of the Hemophilia Council of California.
11/20/2024	Montage Health Foundation	See Attachment #2.
12/04/2024	Patty Harvey	After listening to many hours of your November board meeting, it seems that OHCA is not on an effective trajectory to accomplish its stated and laudable goal; namely, affordability. That affordability drives access and quality is clear. But what are the actual barriers to affordability? To achieve your mandates, you rely on collecting an enormous amount of data. Collecting data can be used to facilitate the solution of applying global budgets to hospitals, for example. But, unfortunately, using it as a basis to impose a three per cent or even more on spending increases, even with the threat of

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		eventual fine, is never going to deliver what you seek. Why is that? Looking in from the outside we see that the real barriers to affordability are: 1). COMPLEXITY: Witness the complexity that already exists in our current system due to the convoluted mix of payers, their complicated codes and regulations, their processes of delay, denial and circuitous methods of overcharging to increase profits. To achieve its goal, OHCA will only result in creating an expensive but increasingly complex system with additional layers of bureaucracy. We end by missing the forest for the trees. 2). HIGH OVERHEAD AND PROFIT: These twin culprits of out-of-control expense in health care are imposed by health insurance entities, pharmaceutical companies and privatized programs raising costs and burdening every aspect of health care delivery. The ongoing fraudulent and unethical behavior of these for-profit agencies, reaping billions of dollars in overpayments (money that does NOT go to health care), create additional barriers to affordability. 3). VALUE BASED PAYMENT PROGRAMS AND ALTERNATIVE PAYMENT MODELS: Additional complexity and negative consequence of allowing private interests to control health care is the product of supposing that extending insurance risk to providers will encourage savings. Yes, it may, but with the incentive to save ultimately resulting in reduction of access and quality, not to mention erosion of doctor-patient relations and ethical moral injury. We must point out that the drive to eliminate fee-for-service is based on a historical inaccuracy that falsely concluded that it is this form of payment that drives our health care expenses—a myth that Nixon used to further his goal of privatizing Medicare with the onset of managed care programs: https://www.corporatecrimereporter.com/news/200/kip-sullivan-on-the-creeping-privatization-of-medicare/ 4). CONSOLIDATION: OHCA does understand that the trend to consolidate institutions both horizontally and vertically is a huge factor driving up the costs of our health care. We are perplexed as to how an additional collection of data by OCHA regarding such a trend can contribute to slowing down inflated costs when it does not have the authority to stall this activity. It appears that this activity will add to OCHA's (and California's) administrative costs. The Office of the Attorney General has a history of investigating various consolidations and already has the authority to stop them. All of which begs the question: Why is OHCA embarking on this road that will, conclusively, continue to tacitly accept and maintain multiple for-profit (and some not-for-profit) payers and private investors that contribute nothing to actual care? These entities are the ones that present the very affordability barriers you are

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		trying to avoid. Trying to stem their greed for ever more profit and surplus capital for themselves and investors only further imbeds their legitimacy and hegemony over our health and safety. The final question that is hard to overlook but is never mentioned in your discourse is that decades of study and analyses across the political spectrum, including lately the CBO, have determined that real affordability lies in pursuing a universal, non-profit, single-payer healthcare system available to all regardless of employment, age, ethnicity, or any other identifier from birth to death. Such a system is shown to project national savings of some billions per year and would put us on par with every other industrialized democracy that now spends half that we do and have enormously better health outcomes. It is baffling to us and to the polled majority of the population why the powers that be continue to apply band-aids to our failing system instead of simply applying this obvious cure. OHCA would do better to make use of its data gathering to perfect the application of a single-payer system.
12/05/2024	Patrick Pine	See Attachments #3 and #4.
12/11/2024	Salinas Union High School District	See Attachment #5.
12/12/2024	California Hospital Association	See Attachment #6.
12/12/2024	Health Access California	See Attachment #7.
12/12/2024	Carol Mone	With regard to the mandate of the Office of Healthcare Affordability, may I comment that Alternate Payment Models throw middlemen into the healthcare mix, increasing costs and offering multiple opportunities for gaming the system. Why are we doing this instead of moving more directly to a single payer system? Just more lipstick on the pig when the pig itself has to go! This whole expensive idea of an office of affordability will NOT make health care more affordable. Those who need to make a profit will still make a profit. Instead it will increase costs to consumers of healthcare and worsen health inequities. I am tired of Orwellian names that say the opposite of what they are. We need to take profit out of healthcare in California Only a health

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		care system free of profit can lower costs and improve care! The money wasted running this cumbersome bureaucracy might be more useful providing healthcare services to the residents of California.
12/12/2024	California School Employees Association Monterey County Council	See Attachment #8.

November 20, 2024

Elizabeth Landsberg, Director
California Department of Health Care Access and Information
Vishaal Pegany, Deputy Director
Office of Health Care Affordability.
Health Care Affordability Board, Members

Submitted electronically to: ohca@hcai.ca.gov

Re: Proposed Quality and Equity Measurement, November Board Meeting: Concerns from Rare Disease Patient Community

Dear Director Landsberg, Deputy Director Vishaal Pegany, and Health Care Affordability Board Members,

On behalf of the Hemophilia Council of California (HCC) and the California Rare Disease Access Coalition, I am writing to express our concern regarding the proposed Quality and Equity Measurement Set, as detailed in the November Office of Health Care Affordability Board meeting materials. HCC's mission is to promote access to care and advance the quality of life for people living with bleeding disorders through advocacy, education, and outreach. The California Rare Disease Access Coalition is a coalition of rare disease patient advocates organizations which aims to advocate on behalf of the rare disease population in health care public policy formation in California.

The Proposed Quality and Equity Measurement Set Completely Ignores Rare Disease Patients, Which Makeup One in Every Ten Patients

According to the National Institutes of Health, rare diseases affect about 1 in 10 people (or 30 million people) in the U.S.[1] While we applaud OCHA for focusing on diseases such as heart disease, asthma and others, we are concerned by the complete lack of focus on the rare disease community in the proposed Quality and Equity Measurement Set (Hereinafter "proposed measurement set.") For example, the proposed measurement set includes chlamydia screening in women, which while an important

[1] About | GARD

metric, is a disease which is estimated to impact roughly 500 per 100,000 people[2], far less than 1 in 10 people which have a rare disease.

We urge OHCA to include rare disease patient access to testing, treatment, and strategies for reducing the diagnostic journey as a quality measurement. Around 80% of rare diseases have a genetic cause, almost 70% of which are present in childhood, yet the diagnostic journey for those with rare diseases is long and complicated, with an average time for an accurate diagnosis is 4·8 years.[3] Having an early genetic diagnosis has also been associated with a reduction in both treatment costs and the incidence of financial hardship related to rare diseases.[4] Delayed diagnosis is frequent due to lack of knowledge of most clinicians. As a result, computerized diagnosis support systems have been developed to address these issues, relying on rare disease expertise and taking advantage of the increasing volume of generated and accessible health-related data. Studies have found that diagnostic decision support systems (DDSS) used early by primary care physicians and specialists are able to significantly shorten diagnostic processes.[5] By failing to include access to genetic testing and specialized treatments for patients with rare diseases, as well as promoting strategies to overcoming diagnostic delays for rare disease, OHCA is missing an opportunity to reduce spending growth in patients living with rare diseases, by shortening the diagnostic journey and delays to specialized treatments.

Individuals with rare disease are often a neglected and marginalized group and, to this end in 2021, the United Nations embraced the first resolution on addressing the challenges of persons living with a rare disease and their families, calling on Member States to provide access to safe and affordable health services, particularly at the primary-care level for people with rare disease. The UN Resolution states:

> "8. Further urges Member States, United Nations agencies and other stakeholders, in consultation with persons living with a rare disease and their families, including through their representative organizations, to design and implement policies and programs, to share experiences and best practices with the aim of fulfilling the rights of all persons living with a rare disease, and to ensure that the implementation of the 2030 Agenda for Sustainable Development is inclusive of and accessible to persons living with a rare disease;"

We are hopeful that OHCA will follow the UN Resolution and "design and implement policies and programs" for persons living with a rare disease by including rare disease patient access to diagnostics and treatments, while promoting evidence-based strategies to shorten the diagnostic journey in their proposed quality metrics. By failing to include rare disease patients, OHCA is missing an opportunity to explore options to reduce spending growth in this patient population by shortening the diagnostic journey

[2] Chlamydia Facts and Statistics: What You Need to Know
[3] The landscape for rare diseases in 2024 - The Lancet Global Health
[4] The landscape for rare diseases in 2024 - The Lancet Global Health
[5] Health economic benefits through the use of diagnostic support systems and expert knowledge - PubMed

and delays to specialized treatments. Should you have any questions regarding our comments please feel free to contact me via email at lkinst@hemophiliaca.org.

Regards,

Lynne Kinst
Executive Director
Hemophilia Council of California

Attachment #2

November 19, 2024

Members of the Office of Healthcare Affordability Board
2020 W. El Camino Avenue
Sacramento, CA 95833

Sent via email.

Subject: Follow up to your inquiry regarding our planned cost reductions

Dear Board Members:

We thank you for your inquiry regarding our planned cost reductions. We are grateful for the opportunity to provide additional information about Montage Health's community affordability initiative which aims to identify and implement $50 million in cost reductions over the next 24 months.

The initiative is part of a long-term strategy to find efficiencies, cost savings and alternative revenue streams in order to apply those savings to a reduction in the cost of services. This is an initiative that has been in place for years and is ongoing. It has the full support of our Board of Trustees and is informed by our internal leadership as well as an objective, third-party consultancy which informed this project with a number of recommendations. Ultimately the purpose is to make our fees for service more affordable; this while ensuring that those areas of care which are critical to our community but are financial loss leaders are maintained; and that our enterprise-wide financial future is secure.

We have conducted a rigorous analysis to identify where and how efficiencies can be realized. We are committed to undertake efforts in the following areas:

1. **Patient care staff productivity improvements**
   a. Implementing staffing reductions, which we anticipate will result in about $25 million in cost savings. This will include patient facing positions, administrative staff, and management personnel. These reductions will necessarily limit the growth of several clinical programs.

b. We will also not move forward with several planned specialty physician additions for our affiliated medical group that had been planned for 2025 to meet community access challenges. We will reconsider these positions in future years.

2. **Improving inpatient and emergency room patient throughput**
    a. Aligning patient length of stay with industry benchmarks while ensuring optimal recovery will provide $6 million in potential cost savings. We expect to realize approximately 33% of these savings in 2025.
    b. Improving emergency room efficiencies provides $1.5 million in potential cost savings. Implementation is under evaluation.

4. **Reduced supply costs and reductions in purchased services**
    a. $1.6 million in physician preference item supply costs have been identified; 100% of which will be realized no later than 2025.
    b. $4.9 million in software expense reductions have been identified and are being implemented over the coming 24 months.
    c. $1.1 million in physician support expenses have been identified for reduction.

The savings detailed above amount to approximately $41 million. We recognize that there is still more work to be done to fully achieve our cost-saving goals over the next 26 months. Note that as one of the largest private employers in the region, we are committed to maintaining our workforce and supporting the local economy. However, there must be a shared understanding that reducing provider expenses to enable the consequent lowering of rates paid to providers will inevitably impact jobs. Adverse impacts to provider revenue directly translate to negative impacts on employee hours and workforce size. Given that 60% of our expenses are related to our workforce, reducing staffing costs will be essential to meet the requirements set forth by OCHA. While we are deeply dissatisfied with having to take this route, **we *intend to utilize turnover and vacancy rates to achieve these changes wherever possible.*** Nonetheless, there may be circumstances where this approach is not feasible.

As you all are keenly aware, it is the responsibility of a community healthcare system to be financially viable, sustainable, and credit-worthy so that we can meet the demands of *all* our community members regardless of their healthcare coverage. We are making our decisions guided by the need to reduce the cost of care while, at the same time, ensuring that we do not join the long list of California hospitals that are in financial distress. We remain committed to exploring all viable options to meet these targets while minimizing the impact on our valued employees and the community.

Additionally, with these cost-saving measures being implemented, and those we already have in place, we remain steadfast in our efforts to implement targeted rate reductions in payor contracts that benefit local employers and their employees. As one example, recently, we successfully contracted with a major local employer, ensuring that their employees receive care locally at reduced costs. The majority of these employees are low-wage service workers in the hospitality industry.

We appreciate the board's interest in our progress to date, and hope that our sharing of these details is reciprocated by OHCA and its Board. Your pending investigation of Monterey County is without precedent, and of concern to us here at Montage Health. Our cooperation should be expected, and we would appreciate timely and advance notice of the procedures, timeline, and parties that are to be involved. There are no statutes that govern or define these steps.

Independent of the investigation that OHCA has announced, Montage Health continues to welcome a collaborative dialogue with OHCA, its Board, and HCAI staff. In a meeting with former Secretary Mark Ghaly, on August 23, 2024, the Secretary indicated that OHCA was committed to continued work with the leadership of Monterey County's hospitals to seek an informed and sustainable path towards more affordable care in this unique and challenging market. We, once again, want to extend an invitation to continue the dialogue that Secretary Ghaly promised.

Sincerely,

Steven Packer, MD
President & CEO
Montage Health

The ROBERT F. KENNEDY MEDICAL PLAN
P.O. Box 47 La Paz Keene, California 93531 (661) 823-6900

December 5, 2024

David M. Carlisle, MD, PhD
Dr. Sandra Hernandez
Kim Johnson
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan

DELIVERED VIA EMAIL

Dear OCHA Board Members and Staff:

On behalf of United Farm Workers and the Robert F. Kennedy Farmworkers Medical Plan (RFK Plan) I want to thank you for listening to our pleas to set limits on hospitals in Monterey County to address the relatively high prices in that region sooner rather than later. We appreciate your taking the time to travel to Monterey for a hearing. We appreciate your bringing other independent sources to validate our contentions that the hospital prices in Monterey County are exceptionally high by any comparative metric. We appreciate that the OHCA staff has worked diligently to provide information that is relevant to your decision making.

My brief argument – as a payer of claims incurred by many of those our plan covers for many years in Monterey County but also in other parts of California and six other states – is that commercial payers have always been willing to pay as much as two times what Medicare would pay for the same services but we feel that demands for three or more times what Medicare pays is unreasonable. We agree that MediCal reimbursements have not been enough to cover full cost and that Medicare arguably is close to covering costs for most services. We do hope that the recent passage of Proposition 35 will improve the level of reimbursements to hospitals and related providers.

Therefore, we have contended that commercial payers paying more than 1.5 to two times Medicare should more than offset the shortfalls for most reasonably well managed hospitals. We also note that Monterey County Medicare prices are indexed higher to recognize the higher costs in the area generally. A recent study suggests that a payment cap of 200% of Medicare for state employee health plans would have a minimal impact on operating margins. Article added to supplement this letter.

We generally have found all three Monterey County hospitals demand that commercial plans pay at least 70% of the hospital's bills. That will usually result in a payment that is at least three times what Medicare would pay. Our contention is that we know that other hospitals in other parts of California and in other Western states with comparable case mixes readily accept 1.4 times to two times what Medicare pays using a lower weighted Medicare index and hence are accepting payments for the same services well under the levels in Monterey County.

Most of the money we receive to pay for the health care services for those the RFK Plan covers comes from major employers in the region. They are constantly under pressure to keep prices down and the grocers who purchase from them apply unrelenting pressure on them. Those employers expect us to find ways to keep our Plan costs down and work hard to meet those expectations,
Our annual increases have been less than three per cent for many consecutive years – but that only is possible by our continuous efforts to control our overhead but also to engage in frequent conflict with hospital finance managers and staff – especially in Monterey County.

We are asking hospitals in Monterey County to meet the same expectations we have long been asked to meet and to do that now – not further down the road.

Respectfully submitted,

Patrick J. Pine

Administrator, Robert F. Kennedy Farmworkers Medical Plan

Hospital Payment Caps Could Save State Employee Health Plans Millions While Keeping Hospital Operating Margins Healthy

- Roslyn C. Murray,
- Christopher M. Whaley,
- Erin C. Fuse Brown, and
- Andrew M. Ryan

Abstract

State employee health plans are consuming an ever-larger portion of state budgets because of rising health insurance premiums. Often the largest purchaser of commercial health insurance in their state, state employee health plans possess a unique opportunity to implement cost containment strategies. This study estimated potential savings from hospital payment caps among state employee health plans and the impact on commercial hospital operating margins. Using data from forty-six states and Washington, D.C., we estimated that payment caps set at 200 percent of Medicare rates would have saved state employee plans an average of $150.2 million per state in 2022 (0.35 percent of state expenditures), leading to aggregate savings of $7.1 billion nationally. Commercial hospital operating margins would remain healthy under this cap, falling from an average of 42.7 percent to 41.7 percent. Payment caps are a promising purchasing strategy for states to generate substantial reductions in health care spending.

State budget constraints and limits on deficit spending create challenging trade-offs between funding state operations and social services and avoiding raising taxes. State employee health plans, which provide health insurance coverage for state and local government employees (for example, legislators, executive branch and municipal employees, and public school and university teachers) and their dependents, are consuming a larger portion of state budgets because of the rising costs of providing health insurance.[1–3] Average total premiums for state employees increased 35 percent from 2013 to 2022, primarily because of rising drug and hospital prices.[4–6] To alleviate budgetary pressures, state plans have increasingly resorted to strategies that ultimately limit access to care or shift costs onto workers through higher deductibles or premium increases.[7]

As an alternative, state plans can pursue strategies to reduce the price of health care services. One key example is the Oregon state employee plan's implementation of a hospital payment cap starting in October 2019. Oregon's legislation limits hospital payments to 200 percent of Medicare rates for in-network inpatient and outpatient

facility services or 185 percent of Medicare rates for out-of-network services. The policy generated substantial savings, amounting to $107.5 million, or 4 percent of plan spending, in the first twenty-seven months of implementation, with all hospitals remaining in network.[8]

A concern with assertive purchasing strategies is that they could threaten the financial stability of hospitals. Although many hospitals have historically maintained positive and increasing margins, there is significant variation across the US.[9,10] Industry groups and stakeholders frequently argue that hospitals will be unable to sustain losses from payment reductions, which would jeopardize essential services.[11]

The financial implications of implementing hospital payment caps across all state employee health plans nationwide remain uncertain. This study estimated the potential savings that state employee health plans can generate through hospital payment caps. In addition, we explored how these savings may vary according to certain design elements and assumptions, and we assessed the impact of payment caps on commercial hospital finances. By examining the fiscal impact of such measures, policy makers can assess the viability of payment caps as a means to mitigate state fiscal challenges.

Study Data And Methods

Data

Our study used 2022 data from multiple sources: the Hospital Price Transparency Study (round 5), published by an employer-led transparency initiative;[12] the National Academy for State Health Policy (NASHP) Hospital Cost Tool; and the 2022 State Employee Health Plan Survey from Georgetown University's Center on Health Insurance Reforms (see online appendix exhibit A1).[13]

The Hospital Price Transparency Study collects medical claims data from state all-payer claims databases, health plans, and self-funded employers to improve hospital price transparency. It covers about 85 percent of US general acute care and critical access hospitals. Our study's main variables included hospital-level data on average facility price per inpatient stay and outpatient service, price as a percentage of what Medicare pays for an inpatient stay or outpatient service (that is, "relative prices"), and number of inpatient stays and outpatient services. Average prices were adjusted for service mix.

The NASHP Hospital Cost Tool provides hospital financial data from the Medicare Cost Reports. We used hospital commercial operating margins, which represent earnings from services provided to commercial patients and exclude nonpatient-related income and expenses. NASHP's measure differs from traditional calculations by focusing solely on income and expenses related to patient services. We focused on profitability from commercial patients because the policy affects a subset of hospitals' commercial volume and revenues.

Finally, the Center on Health Insurance Reforms' 2022 State Employee Health Plan Survey provides data on the proportion of the employer-sponsored insurance population enrolled in state employee health plans at the state level. In the absence of public data on state employee plan prices, we estimated savings based on overall commercial price levels and volume and then applied the share of people with employer-sponsored insurance covered by state employee plans to derive our savings estimates.

We limited our analysis to 4,083 hospitals from the Hospital Price Transparency Study. We excluded fifty-eight hospitals in Oregon, where payment caps were already in place in 2022, and sixty-one in New Jersey and forty-eight in South Dakota because of missing state employee plan data. We also excluded 1,365 hospitals because of missing variables, and we excluded 74 hospitals with inaccuracies in commercial net patient revenue. Our final sample included 2,477 hospitals.

Analysis

To calculate each hospital's Medicare-equivalent payment in both the inpatient and outpatient settings, we used average facility prices, relative prices, and service volumes from the Hospital Price Transparency Study. We calculated each hospital's average facility price at 200 percent of Medicare rates. Changes in hospital revenue were calculated by subtracting revenue under the payment cap from the revenue without the cap. We assumed that prices would only change for hospitals with prices above the cap and that 7.7 percent of the price change was passed to enrollees through out-of-pocket spending.[14] We adjusted for an increase in service volume (resulting from lower costs to state employees), using a price elasticity of demand of −0.2.[15–17] This adjustment reflected findings from Oregon's payment cap, which led to reductions in out-of-pocket spending and increases in service use among state employees.[18]

Because the Hospital Price Transparency Study covers only a portion of the commercially insured population, we calculated an adjustment factor using NASHP data on commercial net patient revenue. This allowed us to scale our savings estimates to the entire commercially insured population. We summed the spending reductions across hospitals to estimate state-level savings and applied the share of employer-sponsored insurance enrollees covered by state employee health plans to identify state employee plan savings (see the Appendix Methods for a detailed description).[13]

We conducted additional analyses to estimate savings under alternative scenarios: excluding critical access hospitals, hospitals with fewer than fifty beds, or hospitals in areas with a population of fewer than 20,000 because Oregon's policy exempts these hospitals; excluding safety-net hospitals (those in the top quartile of the Disproportionate Share Hospital Index for each state); and applying an alternative cap based on median facility prices relative to Medicare payments for all hospitals in each state. We also tested two alternative assumptions: no increase in service use, and price increases for hospitals with prices below the 200 percent cap.[19–21]

Finally, we compared state-level commercial hospital operating margins under three scenarios: without a cap, with a 200 percent payment cap for both in- and out-of-network payments, and with a cap based on state-specific median relative prices. NASHP calculates commercial hospital operating margins by dividing commercial operating profit (commercial net patient revenue minus operating costs) by net patient revenue. To calculate margins under the two cap scenarios, we deducted estimated state employee health plan savings from the numerator and the denominator at the hospital level. We then aggregated commercial operating profits and net patient revenue to the state level to account for hospital size, and we calculated a state-level margin.

Limitations

The reliability and representativeness of our findings are subject to limitations stemming from the data sources available for use in our study. With no public data on state employee health plan prices, we used commercial pricing data from the Hospital Price Transparency Study. Previous research indicates that before the payment cap, Oregon's state employee health plan paid higher rates than commercial payers,[8] suggesting that savings may have been underestimated. Conversely, some state employee health plans might have secured lower prices than commercial payers because of their size and bargaining power, which could have led to an overestimate of the savings. For most states, overall commercial prices are likely a reasonable approximation for state employee prices. In addition, assuming that the patient mix between state employees and the broader commercial population is identical may have affected the accuracy of our estimates. However, data from Oregon indicate that state employees have age profiles and case-mix indices comparable to those of the commercial population.[8]

Further, there are concerns about the representativeness of the Hospital Price Transparency Study, as our savings estimates relied on statewide commercial prices and service use. That study combined data from twelve state all-payer claims databases with additional contributions from self-insured employers and health insurance plans that chose to participate. Thus, service volume and commercial revenue estimates were lower than national levels. To scale our estimates, we derived hospital-level adjustment factors using NASHP's commercial net patient revenue. The adjustment factors were notably smaller in the twelve states with all-payer claims databases than in those without, reinforcing the credibility of our approach.

Although the Medicare Cost Report data, accessed through NASHP's Hospital Cost Tool, afforded us a timely and comprehensive perspective on hospital finances, their lack of consistent auditing and reporting raised concerns regarding data accuracy.[22] In addition, missing data on state employee health plan coverage in the Center on Health Insurance Reforms survey could have led to underestimations of both enrollment percentages and resulting savings. Further, recent research shows minimal volume responses to price increases after hospital mergers, suggesting that our current

estimates might be conservative if we overestimated volume changes.[23] Therefore, we conducted a robustness test assuming no volume response.

Finally, in response to potential revenue reductions, hospitals may resort to revenue-generating tactics that would reduce state savings. Tactics include increasing service volume, prices for nonregulated commercial patients (that is, "cost shifting"), or prices for nonregulated services (for example, professional fees). Our analysis did not account for these potential responses. The evaluation of Oregon's payment cap found no evidence of cost shifting, aligning with the broader body of research on this topic.[8,24–26] However, further research on the other potential responses is needed.

Study Results

Composition Of Sample

Our analysis covered 2,477 hospitals from forty-six states and Washington, D.C. (referred to as "states"). On average, each state had fifty-three hospitals, with numbers ranging from five in Delaware and Washington, D.C., to 225 in California (exhibit 1 and appendix exhibit A2).[13] A total of 711 hospitals were small or rural. On average, 8.1 percent of employer-sponsored insurance enrollees were covered by state employee plans, ranging from 1.7 percent in Indiana to 20.9 percent in West Virginia. Average inpatient facility prices were 255.3 percent of Medicare prices, and outpatient facility prices were 312.7 percent of Medicare prices. The lowest and highest relative inpatient facility prices were in Iowa (167.6 percent) and Georgia (373.3 percent), although the lowest and highest relative outpatient facility prices were in Arkansas (141.7 percent) and Florida (470.3 percent). State employee facility revenue averaged $512.8 million per state, totaling $24.1 billion across all states.

Exhibit 1 Characteristics of state employee health plans and hospitals across study sample states, 2022

	Total	Mean	Median	25th percentile	75th percentile
State employee plan facility revenue ($ millions)	**24,101.7**	**512.8**	**300.3**	**163.2**	**672.6**
State employee plan enrollees as share of ESI enrollees (%)	**— a**	**8.1**	**6.1**	**3.2**	**13.3**
Relative prices (% of Medicare prices)					
Inpatient facility	**— a**	**255.3**	**251.9**	**221.1**	**286.7**
Outpatient facility	**— a**	**312.7**	**313.0**	**270.5**	**347.6**
No. of hospitals	**2,477**	**53**	**36**	**19**	**74**
No. of small, rural hospitals exempted under alternative scenarios	**711**	**15**	**10**	**5**	**19**

SOURCE Authors' analysis using 2022 data from the Hospital Price Transparency Study (round 5), the National Academy for State Health Policy Hospital Cost Tool, and

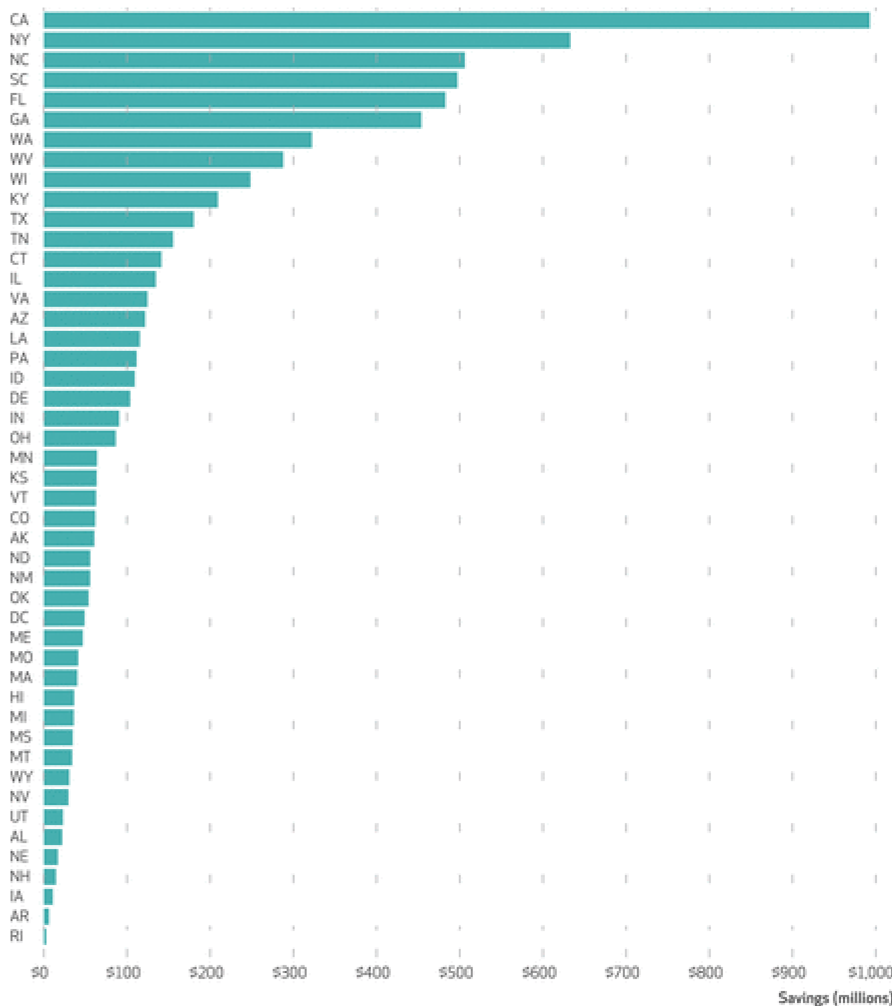
the 2022 State Employee Health Plan Survey from Georgetown University's Center on Health Insurance Reforms. NOTES Sample includes 46 states and Washington, D.C. ESI is employer-sponsored insurance.

a Not applicable.

Estimated Savings Under A 200 Percent Cap

We estimated that a 200 percent cap on inpatient and outpatient facility payments would have saved state employee plans in forty-seven states an average of $150.2 million in 2022, leading to aggregate savings of $7.1 billion (appendix exhibit A2).[13] Annual savings estimates ranged from $2.7 million in Rhode Island to $993.0 million in California (exhibit 2). On average, the states in our sample would have saved 0.35 percent of their state budgets by implementing a payment cap, ranging from 0.02 percent in Arkansas to 1.54 percent in South Carolina (appendix exhibit A3).[13]

Exhibit 2 Estimated annual state employee health plan savings from limiting hospital facility payments to 200% of Medicare rates, by state, 2022

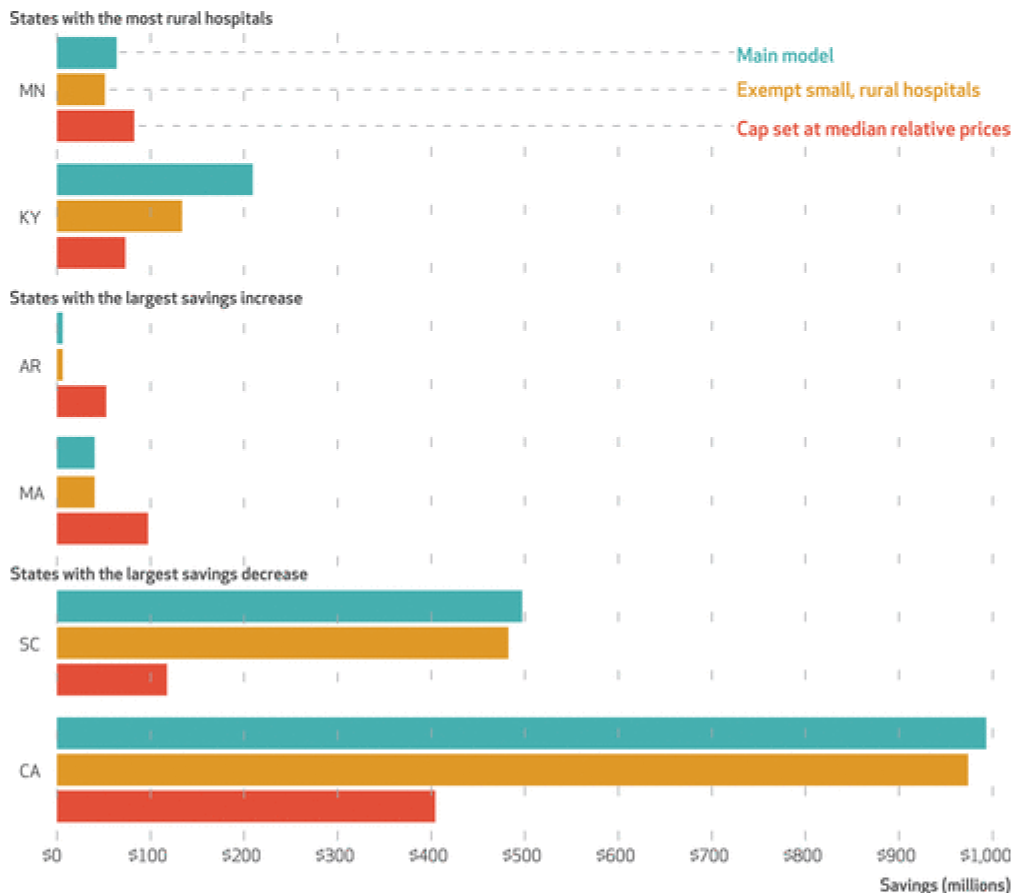


SOURCE Authors' analysis using 2022 data from the Hospital Price Transparency Study (round 5) and the National Academy for State Health Policy Hospital Cost Tool. NOTES Figure shows annual state employee health plan savings for the 46 states and Washington, D.C., included in this analysis. States appear in order of the size of annual savings estimated from a cap on hospital facility payments equaling 200% of Medicare rates. Total savings amount to $7.1 billion across states, with a mean of $150.2 million, median of $63.4 million, and interquartile range of $35.8 million–$155.3 million (appendix exhibit A4; see note **13** in text).

Estimated Savings Under Alternative Designs And Assumptions

Exempting small or rural hospitals would have resulted in $141.0 million in savings, on average, leading to aggregate savings of $6.6 billion in 2022 for state employee health plans (appendix exhibits A4 and A5).[13] Average and total savings would have declined to $114.6 million and $5.4 billion, respectively, if states had exempted safety-net hospitals. Caps set at median relative prices would have generated average state-level savings of $59.7 million, totaling $2.8 billion nationwide in 2022. The impact of these alternative designs on state-level savings differed across states (exhibit 3).

Exhibit 3 Estimated annual state employee health plan savings under alternative design choices for hospital payment caps, selected states, 2022



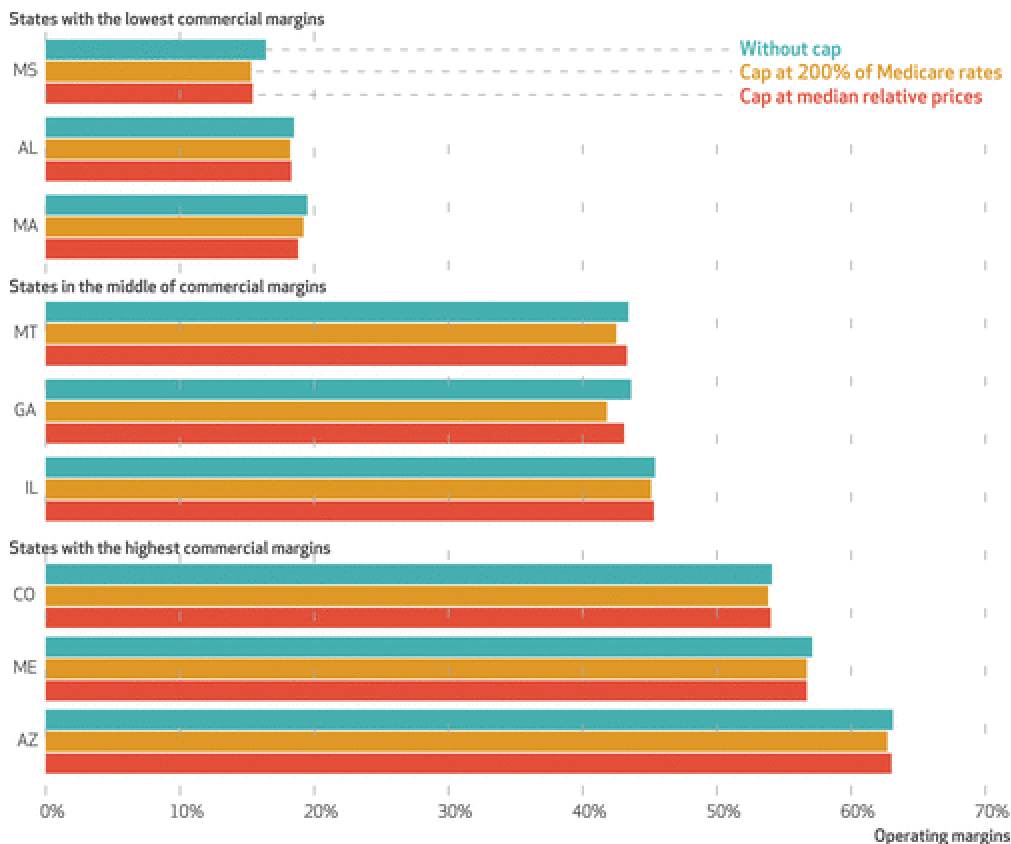
SOURCE Authors' analysis using 2022 data from the Hospital Price Transparency Study (round 5) and the National Academy for State Health Policy Hospital Cost Tool. NOTE Figure shows annual state employee health plan savings for six states comparing savings when capping hospital facility payments at 200% of Medicare rates (main model); exempting small, rural hospitals; and setting the cap at median relative hospital prices in a state.

In supplemental analyses, results were similar when we assumed that there was no volume response and that low-price hospitals increased their prices (appendix exhibits A6–A8).[13]

Estimated Change In Commercial Hospital Operating Margins

Without payment caps, state-level aggregate commercial hospital operating margins were 42.7 percent, on average, in 2022. Commercial operating margins would have been 41.7 percent, on average, under a 200 percent cap and 42.3 percent, on average, under a cap set at median relative prices (appendix exhibits A9 and A10).[13] The effect of a cap set at 200 percent of Medicare prices or at median relative prices, compared with having no cap, on state-level hospital commercial margins varied across states (exhibit 4).

Exhibit 4 Commercial hospital operating margins across payment cap scenarios, selected states, 2022



SOURCE Authors' analysis using 2022 data from the Hospital Price Transparency Study (round 5) and the National Academy for State Health Policy Hospital Cost Tool. NOTE Figure shows aggregate commercial hospital operating margins for 9 states comparing margins without a cap to margins capping hospital facility payments at 200% of Medicare rates and at median relative hospital prices in a state.

Discussion

We estimated that a cap of 200 percent of Medicare rates on hospital facility payments would have saved state employee health plans in forty-six states and Washington, D.C., an average of $150.2 million (0.35 percent of state expenditures), totaling $7.1 billion nationwide in 2022. We estimated that revenue losses from the cap would have had a minimal effect on aggregate commercial hospital operating margins at the state level because state employees represent a relatively small share of hospital volume.

To our knowledge, no other research to date has examined the impact of hospital payment caps for state employee plans. However, several studies have modeled savings for the broader commercial market. Two studies examined the impact of a cap set at 200 percent of Medicare prices, projecting annual savings between $42.7 billion and $100.0 billion.[14,27] Extrapolating our results to the entire commercial market, we estimated that prices capped at 200 percent of Medicare prices would have saved $87.7 billion in 2022, in line with prior estimates (see the Appendix Methods for our calculation).[13] Another study estimated that setting price caps at five times the twentieth percentile of commercial prices for each service in each market, equivalent to a cap set at 500 percent of Medicare prices, could generate annual savings of $38 billion.[28,29] This would result in fewer savings compared with the estimates from our study and others regarding savings from a 200 percent cap.

As of November 2024, Oregon had the only state employee plan to have implemented legislatively mandated caps on hospital facility payments. Research evaluating the Oregon program found that the 200 percent cap generated $107.5 million in savings in the first twenty-seven months of the policy, or $47.8 million annually. The absence of hospital departures from insurance networks or closures may indicate that Oregon's hospitals have effectively managed the impact of the payment cap.[8] The Montana state employee health plan had a similar program in place from 2016 to 2022, in which the state negotiated payments with each hospital, based on a percentage of Medicare payments. An independent audit of the program estimated that the state saved $47.8 million over the course of the first three years of the program, or $15.9 million per year.[30] However, the program was later abandoned without a formal evaluation because of political pressures.[31] An attempt by the North Carolina treasurer in 2019 to contract with providers on a percentage-of-Medicare basis for the state employee health plan also failed because of substantial resistance from providers.[32] Both of these examples suggest that legislation may be more durable against repeal or abandonment than contract negotiation.

Policy Implications

Hospital payment caps have the potential to generate substantial savings for state employee health plans, with limited impacts on hospitals' commercial operating margins. **Although our primary analysis focused on state employee plans, payment caps set at comparable levels could generate significant savings if extended to all commercially insured people within a state**. However, a broader application might result in a more pronounced impact on hospitals' finances. Regardless of the scope of application, states should consider several design factors.

First, some states may consider exempting financially vulnerable hospitals from payment caps. However, exempting such hospitals is likely to reduce overall state-level savings. Second, given substantial variation in relative prices, states may want to tailor payment caps to their specific state market conditions. A cap set too high may restrict potential savings, and a cap set too low could put financial strain on hospitals.

Third, legislative language must be carefully written to avoid unintended price responses. For example, hospitals might seek price increases for services priced below the cap. Oregon's original legislation stated that payments "shall not exceed" 200 percent of Medicare prices, and hospitals increased prices to reach the cap in the first year, which reduced savings. The state then revised the legislation to specify that payment shall be "the lesser of" the negotiated rate, billed charges, or the cap. Fourth, states might consider alternative benchmarks. Although Oregon bases its cap on Medicare rates, the cap might not be well calibrated for services that are considered rare or highly complex for Medicare patients, such as maternity or pediatric services. To ensure that a cap applies to these services, states might consider benchmarks such as the median in-network commercial payment.

Fifth, implementing an out-of-network cap set at or below the in-network cap is essential to incentivize hospitals to remain in the network. Sixth, directing savings to enrollees through lower out-of-pocket spending, more generous benefits, premium reductions, or wage increases also is essential. Ensuring that savings reach commercial enrollees in self-funded plans may be challenging for state insurance departments because of restrictions in the Employee Retirement Income Security Act (ERISA) on oversight of these plans, even though payment caps are not subject to ERISA preemption because they regulate hospital, not insurer, behavior.[33]

State policy makers should be prepared to address hospitals' counteracting efforts to mitigate the impact of the cap.

Finally, state policy makers should be prepared to address hospitals' counteracting efforts to mitigate the impact of the cap. Responses might include cuts to staffing or offsetting lost revenue by increasing service volume. The nature of these responses could differ depending on whether the cap is applied broadly to commercial enrollees as well, or exclusively to state employees, who represent a smaller share of hospital revenue. The impact of payment caps on patients' access to care and the quality of that care is unknown and should be monitored.

Conclusion

Our study suggests that state employee plans can use hospital payment caps to alleviate fiscal pressures with potentially limited impact on hospitals. A cap set at 200 percent of Medicare prices would generate substantial savings for many states without a major impact on hospital finances. Tailoring caps to specific classes of vulnerable hospitals could address concerns about hospitals' financial stability while maintaining savings for states.

ACKNOWLEDGMENTS

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Attachment #5

Salinas Union High School District

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Subject: Urging the Imposition of a .1% Sector Target for the Three Most Utilized Hospitals

Dear Dr. Ghaly, Ms. Johnson, Ms. Landsberth, and Mr. Pegany,

As the Assistant Superintendent of Business Services of the Salinas Union High School District, I write to express my deep concern regarding the significant and ongoing increase in healthcare costs, particularly those associated with hospital services. The exorbitant pricing practices of the three most utilized hospitals in our county have placed a substantial burden on our employees and their families. Effective January 1, 2025, our employees will experience a 12.47% increase in medical premiums and a reduction in benefits due to plan changes.

We urge the Office of Health Care Affordability (OHCA) Board to take immediate action by imposing a strict .1% sector target on these three hospitals: Community Hospitals of the Monterey Peninsula (CHOMP), Salinas Valley Health, and Natividad Medical Hospital. This measure is essential to curb excessive pricing and ensure that healthcare remains accessible and affordable for all.

The excessive cost of hospital services has a direct and negative impact on:

- Employees and their families: Rising healthcare costs limit access to essential care and can lead to financial hardship.
- Employers: Increased healthcare costs reduce employers' ability to provide competitive benefits packages and create challenges in attracting and retaining talent.

I strongly urge the hospitals to prioritize patient care over profit and work towards more equitable pricing practices.

I appreciate the work and dedication of the OHCA Board and its staff in addressing this critical issue. Thank you for your time.

Sincerely,

Ana Aguillon
Assistant Superintendent, Business Services
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December 12, 2024

Kim Johnson
Chair, Health Care Affordability Board
2020 W El Camino Ave.
Sacramento, CA 95833

Subject: **CHA Comments for the December 2024 Health Care Affordability Board Meeting**
(Submitted via Email to Megan Brubaker)

The California Hospital Association (CHA), on behalf of more than 400 hospitals and health systems, appreciates the opportunity to comment ahead of the December 2024 Health Care Affordability Board meeting. The Office of Health Care Affordability (OHCA) has an historic opportunity to transform health care delivery in California, but it cannot sustainably promote affordable, high-quality, equitable care without careful deliberation, dispassionate data analysis, and meaningful input from those that deliver care to 39 million Californians. This letter offers an assessment of OHCA's proposal for measuring hospital spending, discusses the importance of encouraging investment across the full continuum of behavioral health care, and raises concerns that the push for sector targets is moving too fast and will ultimately undermine collaboration across the health care sector in fulfillment of OHCA's important mission.

Provisional Hospital Spending Methodology Is a Reasonable Start, With Opportunities for Refinement Over Time

Since April of this year, OHCA has convened the Hospital Spending and Measurement Workgroup to advise on a methodology for measuring hospitals spending. The workgroup includes representatives of hospitals, health plans, purchasers, and consumer advocates and has provided an opportunity for experts from the field to meaningfully engage in the methodology's development. The provisional methodology presented by OHCA staff at the November OHCA board meeting reflects the workgroup's collective work on this effort and is a reasonable starting point for measuring hospital spending, though there are clear opportunities for refinement. As the methodology is implemented and refined, steady and focused engagement with experts from the hospital field must continue.

OHCA's Provisional Approach Has Several Advantages. OHCA staff and the workgroup considered various approaches to measuring hospital spending over time, all of which came with positives and drawbacks. The provisional approach checks a number of important boxes:

- **The Methodology Uses a Tested, Comprehensive, and Transparent Data Source.** The provisional methodology would rely upon annual financial data that hospitals have reported to OHCA's parent department, the Department of Health Care Access and Information (HCAI), for

decades. These public reports contain the vast majority of the information OHCA needs to measure its primary variable of interest — changes in hospital spending — and can be supplemented with additional data also submitted by hospitals to HCAI at the same or similar cadence. Alternative sources of data lack several of the advantages of the existing hospital financial reports. For example, the attribution methodology used in the total health care expenditure (THCE) reports from payers would regularly assign hospital spending to hospitals other than where care was received, such as when patients receive emergency care not provided by the hospital affiliate of their medical group. While HCAI's all-payer claims database theoretically could overcome this and other challenges of the THCE data, this data source is entirely untested and — given other states' reluctance to use such data in their own spending target programs — is likely unsuited to measuring changes in aggregate health care spending over time.

- **Net Patient Revenue Is an Appropriate Measure of Hospital Spending.** OHCA intends to primarily assess hospital spending growth as the annual change in hospitals' net patient revenue, subject to certain adjustments. Net patient revenue is the best measure of hospital spending available in hospitals' financial data. First, the measure hews closely to how OHCA is tracking spending for other providers under its THCE methodology by reflecting final adjudicated payments for health care services rendered. In doing so, it excludes hospital revenues from sources beyond health care, such as parking and cafeteria revenues, leases of real property, and other business dealings beyond OHCA's jurisdiction. Moreover, net patient revenue is reported separately for the three major payer categories that OHCA is concerned with: commercial payers, Medicare, and Medicaid. Other revenue sources are generally not attributable to specific payers and are not reported accordingly.
- **The Methodology Captures Hospitals' Full Mix of Services.** Inpatient care accounted for 62% of all hospital care provided in California in 2023, with outpatient care making up the remaining 38%. OHCA's provisional methodology would capture changes in spending across both types of care, and as a result be more comprehensive than alternative approaches. However, as described below, deficiencies in capturing outpatient volumes and adjusting for outpatient case mix should be evaluated and addressed as the methodology is refined over time.
- **The Methodology Guards Against Major Perverse Incentives.** To succeed in creating a health care system that is lower cost **and** more accessible and equitable, OHCA must carefully consider the incentives its rules create. Fortunately, OHCA's provisional hospital spending methodology includes components intended to mitigate several perverse incentives that otherwise would place equitable access to care at risk, particularly for patients with the highest needs. Specifically, it measures hospital spending growth on a per-patient basis and adjusts for the enormous differences in acuity between different patients and the services that are provided.
    - **Volume Adjustment Protects Access to Care.** First, by accounting for patient volume, OHCA's provisional methodology would not penalize hospitals for seeing more patients. As a result, hospitals would remain incentivized to sustain their service lines and bed capacity and work to attract more patients through better care. The approach is comparable to OHCA's methodology for adjusting health plan and physician organization spending by their number of enrolled or assigned patients, which similarly removes the incentive for these organizations to cut their enrollment or patient panels to meet the spending target.
- **Case-Mix Adjustment Protects Patients with High Needs and Access to Complex Care.** Hospitals serve patients with enormous differences in need, some requiring short-term observation following a routine procedure and others requiring complex procedures, advanced

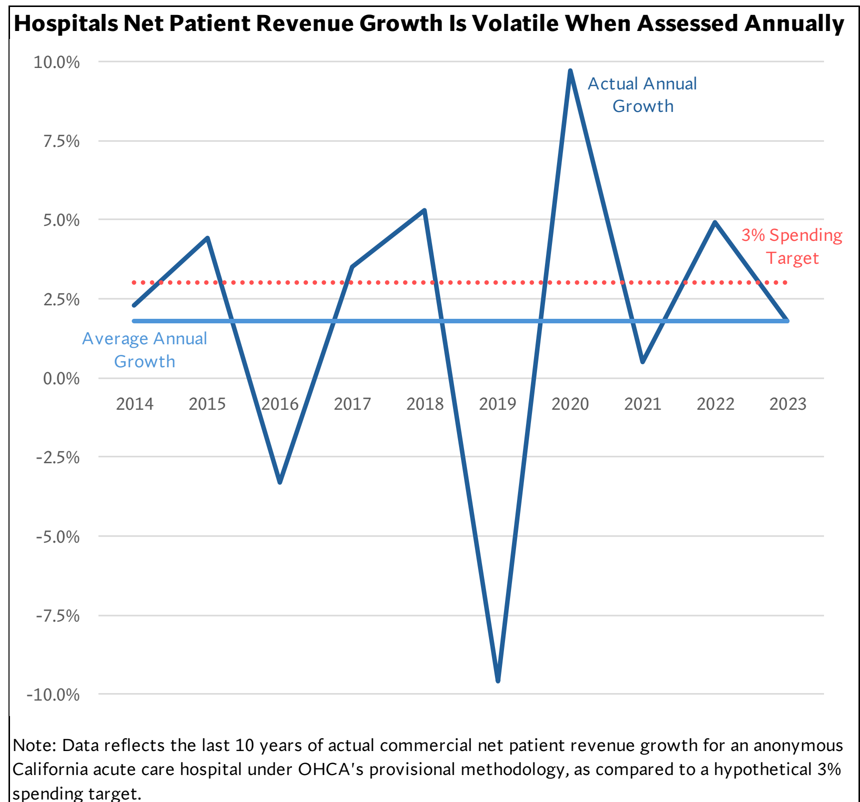
medical equipment, close observation, and prolonged stays counted in weeks, not days. By including a case-mix adjustment, hospitals would not be punished for treating patients with the highest medical needs. Similarly, different hospital services vary enormously in resource intensity. For example, heart transplants are among the most resource-intensive services that hospitals provide. Under Medicare's case-mix adjustment methodology, performing a heart transplant requires 140 times the sources of caring for a healthy newborn post-delivery, while the average length of stay for a heart transplant patient is 29 days, compared to 3 for the healthy newborn. Without case-mix adjustment, cutting heart transplant services could be the fastest route for a hospital to meet the spending target, despite resulting in the loss of life-saving care.

- **Medicare-Based Case-Mix Adjustment Is a Reasonable Starting Point; Alternatives Should Be Evaluated.** OHCA's provisional methodology would rely on the Medicare program's methodology of case-mix adjustment. Theoretically, this is a problem since Medicare's case-mix methodology is based on services used by Medicare's primarily elderly patient population. As a result, it may not appropriately account for hospital services primarily used by children and young adults, such as labor and delivery. Nevertheless, California's hospitals generally have not raised concerns with using the Medicare-based case-mix adjustment methodology, at least at the outset. Unlike other approaches, Medicare's methodology is transparent and readily available to interested users. While other approaches should continue to be evaluated, using the Medicare approach appears sufficient at this time.

The Provisional Methodology Has Deficiencies That Should Be Addressed Over Time.
While the provisional methodology has many advantages, below are several areas that OHCA must target for refinement.

- **Provisional Approach Does Not Account for Differences in *Outpatient* Service Mix and Patient Acuity**. OHCA's provisional approach for case-mix adjustment looks exclusively at hospitals' mix of **inpatient** services and patients, assigns an associated case-mix index score, and then extends that inpatient case-mix index score to the outpatient side. The methodology cannot distinguish between the resource intensity of an emergency department visit to treat a minor wound and an outpatient hip replacement or cancer drug infusion. As a result, large but appropriate changes in hospitals' outpatient service mix could artificially boost their measured growth numbers and cause them to miss the spending target. Unfortunately, there are no readily available approaches available to address this known shortcoming. As the methodology for measuring hospitals spending continues to be refined, OHCA and its dedicated workgroup should prioritize identifying and evaluating alternative approaches to outpatient case-mix adjustment.
- **Case-Mix Index Does Not Appropriately Capture Outlier Cases.** While the case-mix index appropriately captures differences in resource intensity and patient acuity in most cases, it fails to accurately capture the most expensive stays. For example, it does well to differentiate the resource intensity of caring for a patient needing a one-night hospital stay from another needing a four-night stay. However, it falls far short of appropriately capturing the resources needed to care for a patient that stays weeks or months in the hospital, a trend that, unfortunately, is growing increasingly common. OHCA must identify ways to control for such outlier stays as it refines its hospital spending measurement approach going forward.
- **OHCA Must Account for Significant Annual Volatility in Hospital Spending.** Despite the inclusion of adjustments for volume and case mix, year-over-year volatility in hospital spending, as measured under the provisional methodology, is enormous. The figure on the next page demonstrates this using real data for an anonymous California hospital. It shows that over the last decade, its average annual growth in net patient revenue was far below OHCA's (eventual)

spending target of 3%. However, it still would have violated the spending target in 5 out of 10 years. Unfortunately, such volatility is the norm rather than the exception. This means that, to appropriately assess which hospitals had spending growth beyond the spending target, OHCA will have to evaluate growth on a multiyear basis or employ statistical testing that controls for this underlying volatility.



Note: Data reflects the last 10 years of actual commercial net patient revenue growth for an anonymous California acute care hospital under OHCA's provisional methodology, as compared to a hypothetical 3% spending target.

Behavioral Health Investment Benchmark Must Encourage Improved Access Across the Full Continuum of Care.

Behavioral health care is in crisis in California. Insufficient access to care spans the entire continuum of care, from navigation and peer services to therapy, medication-assisted treatment, intensive outpatient services, inpatient psychiatric care, and long-term nursing and supportive care. For inpatient care, a 2021 RAND study found that California was short nearly 5,000 psychiatric beds. The need to invest in the full continuum has been consistently recognized across the major recent efforts to reform California's system of behavioral health care:

- The Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-Connect) aims to *"strengthen the continuum of mental health services for Medi-Cal beneficiaries living with serious mental illness,"* including by ensuring greater access to residential and inpatient treatment and unlocking new federal Medicaid funding.
- The Behavioral Health Continuum Infrastructure Program (BHCIP) is providing billions of dollars to support the construction, acquisition, or expansion of additional treatment capacity, including for residential facilities adding 2,601 beds and 128 outpatient facilities, adding 281,146 slots to the state's outpatient service capacity.
- The Behavioral Health Services Act (Proposition 1, 2024) builds on BHCIP, providing billions of dollars more in funding to expand behavioral health treatment, residential care, and supportive housing for Californians with the highest need.
- Senate Bill 855 (2020), which amended the state's laws to require health plans and insurers to cover behavioral health care at parity with other covered benefits, was written to address inequities in coverage the full range of behavioral health care.
- The California Health and Human Services Agency's Behavioral Health Crisis Continuum Plan from May 2023 ... stated that the behavioral health "*continuum is only complete when connected to more intensive services that can be accessed when medically necessary, and from which people will exit and return to the community where recovery and resiliency support will be critical. This idea of a*

"continuum of care" applies broadly to all levels of care but can be specifically examined from the lens of a complete crisis system."

In establishing its methodology for measuring behavioral health spending and setting an investment goal, OHCA must support — not be at cross purposes with — these broader state efforts to create a complete system of care capable of meeting all Californians' behavioral health care needs. To do so, the behavioral health investment benchmark must include all medically appropriate care settings for which increased access is needed.

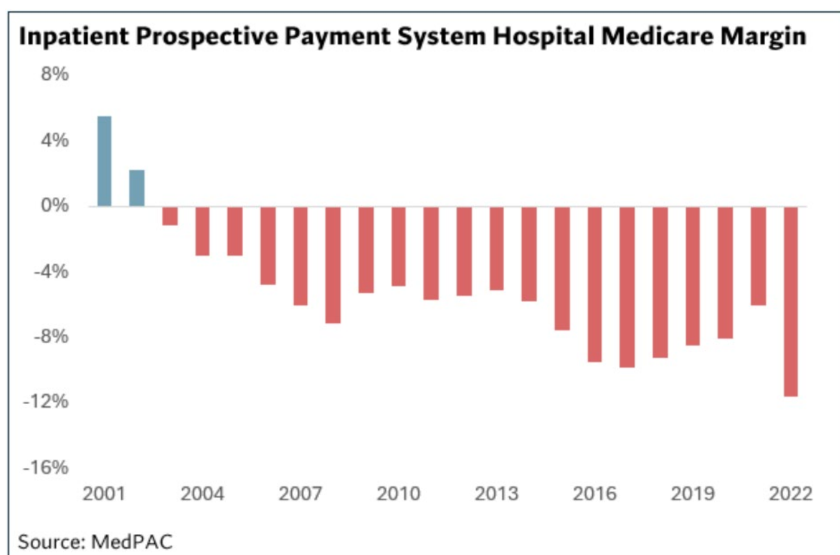
Learning Needed Before Moving Toward Sector Targets

Consideration of Sector Targets Is Premature. The November board meeting continued the discussion on sector targets, focusing on options for differentiating between "high- and low-cost" hospitals for the purpose of differentiating their spending targets. This effort is premature, coming **before** OHCA has:

- Finalized a methodology for measuring hospital spending growth
- Measured or reported statewide or hospital baseline spending growth
- Implemented the state's first spending target
- Set any rules for enforcement
- Meaningfully and impartially analyzed the drivers of health care spending
- Considered whether payers should be allowed to retain savings from lower sector targets on providers in the form of higher earnings
- Fulfilled the requirements of statute on the development of sector targets, including to *"minimize fragmentation and potential cost shifting and that encourages cooperation in meeting statewide and geographic region targets"*[1]

Deficiencies in Medicare Hospital Payment Policies Raise Many Questions About Using Medicare Payments as the Baseline Comparison. An OHCA board member suggested that one way to identify relatively high-cost hospitals is to compare hospitals' commercial reimbursement levels to what Medicare pays them. Unfortunately, growing deficiencies in Medicare payment policy make such an approach increasingly problematic.

- **Medicare Payments Are Becoming Increasingly Insufficient.** Medicare payments for hospital services are updated annually to account for the inflation. However, as the figure on the right shows, due to inadequate inflationary updates, Medicare payment levels are falling farther and farther short of covering hospitals costs in caring for Medicare patients. In fact, these updates have proven so inadequate in recent years that, for federal fiscal year 2024, the Medicare Payment Advisory Committee went so



[1] Health and Safety Code Section 127502(l)(2)(C).

far as to recommend an update 1.5 percentage points higher than required by federal law. The growing failure of Medicare to cover the cost of hospital care calls into question whether OHCA should look to the federal program to guide its assessments of the appropriateness of hospital payments in the commercial market.

- **Deficiencies in Medicare Payment Policies Make Hospitals in High-Cost Areas Inappropriately Appear to Be High Cost.** Comparing hospitals' commercial reimbursement levels to Medicare is further complicated by the fact that hospitals in high-cost areas are increasingly disadvantaged by Medicare payment policies. Research from Stanford and the University of Southern California reveals that Medicare underpayment is much greater for California hospitals located in high-cost regions, as opposed to low-cost regions.[2] For example, while fee-for-service Medicare paid California hospitals in regions with low area wage index scores at close to cost in 2019, it underpaid hospitals with high area wage index scores by upwards of 50% or even 75%. This deficiency in Medicare payment policy inevitably makes hospitals in areas that are disproportionately undercompensated by Medicare appear more expensive, despite their higher commercial rates being necessary to sustain their operations. Accordingly, comparing commercial payments to Medicare benchmark rates would mislead due to deficiencies in how the underlying benchmark rates are determined. Significantly more evaluation is needed before using Medicare payment levels to identify high- and low-cost hospitals.

Conclusion

OHCA has an opportunity to transform health care delivery in California. Meeting this opportunity will require the careful balancing of tradeoffs, evolution as OHCA continues to learn more, and collaboration across the health care sector in pursuit of our shared goals of improved affordability, access, quality, and equity. CHA encourages OHCA to proceed reflectively, with due consideration of the impacts its decisions will have for the 39 million Californians who rely on the state's health care delivery system for their health, lives, and livelihoods.

Sincerely,

Ben Johnson
Group Vice President, Financial Policy

cc: Members of the Health Care Affordability Board:
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Dr. Sandra Hernández
Dr. Richard Kronick
Ian Lewis
Elizabeth Mitchell
Donald B. Moulds, Ph.D.
Dr. Richard Pan
Elizabeth Landsberg, Director, Department of Health Care Access and Information
Vishaal Pegany, Deputy Director, Office of Health Care Affordability
Darci Delgado, Assistant Secretary, California Health and Human Services Agency

[2] Gaudette É, Bhattacharya J. California Hospitals' Rapidly Declining Traditional Medicare Operating Margins. Forum Health Econ Policy. 2023 Mar 7;26(1):1-12. doi: 10.1515/fhep-2022-0038. PMID: 36880485.

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December 12, 2024

The Honorable Kim Johnson, Chair
Health Care Affordability Board

Elizabeth Landsberg, Director
Department of Health Care Affordability and Information

Vishaal Pegany, Deputy Director
Office of Health Care Affordability

Re: December 2024 Health Care Affordability Board Meeting

Dear Ms. Johnson, Ms. Landsberg, and Mr. Pegany,

Health Access, the statewide consumer advocacy coalition committed to quality, affordable health care for all Californians, offers comments and recommendations on the anticipated topics for the December 2024 Health Care Affordability Board meeting, including:

- Affordability of premiums and cost sharing
- Presentations on cost-saving strategies
- Sector targets and high-cost outliers
- Hospital spending measures and categories of hospitals

Affordability of Rates, Including Both Premiums and Cost Sharing
We commend OHCA staff for highlighting the continuing increase in premiums at the national level in last month's Board presentation. We again note that cost sharing matters to consumers as well as premiums, especially now that 80% of California consumers with job-based coverage have deductibles that are often thousands of dollars[1].

Health Access again recommends that OHCA work closely with its sister agency, the Department of Managed Health Care (DMHC), as well as the Insurance Commissioner on rate review to assure that plans and insurers as well as the health care entities paid by the plans and insurers abide by the cost growth targets. Rates need to be actuarially sound, but actuarial soundness ought to reflect a major change in legal requirements such as cost growth targets.

Presentations on Cost-Reducing Strategies that Improve Outcomes and Equity

[1] Dietz et al, 2024: https://laborcenter.berkeley.edu/wp-content/uploads/2024/02/Measuring-Consumer-Affordability_revisedFeb82024.pdf

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Health Access appreciated the presentation by AltaMed on cost-reducing strategies that improve outcomes and equity, particularly for the Medicare and Medi-Cal population. Hearing from those organizations that are committed to the triple aim of lower costs, better outcomes and improved equity is helpful.

Sector Targets: High-Cost Outlier Hospitals

Health Access supports setting a lower cost growth target on "high-cost outlier[2]" hospitals, specifically the top 10% or 20% of hospitals that have the highest prices for inpatient and outpatient services, expressed as a percentage of Medicare. We support the staff suggestion about a combined focus on hospitals that are either high-cost or high-growth or both.

Hospitals account for about 40%-45% of the premium dollar for commercial coverage, more when looking at "total medical expenditures", functionally medical claims. Hospital costs are the single biggest area of spending by health plans. Too many hospitals and health systems are now able to extract payments in excess of 400% of Medicare[3] from commercial payers for hospital costs because of market dominance.

Lowering the rate of growth of hospital costs is essential to slowing the rate of growth in commercial premiums and cost-sharing. Because of the medical loss ratio, health plan administration and profits are driven by increases in "total medical expenditures", that is claims costs. If premiums are $1,000 a month instead of $500 a month, then the health plan administration and profits are twice as much. Other benefit categories such as professional services and outpatient prescription drug costs are also important costs, each amounting to about 20% of the premium dollar. Hospital inpatient and outpatient spending is the single biggest bucket of information with the most data collected for the most years by HCAI.

To measure "high-cost" hospitals will require some measure of the intensity of services provided. An academic medical center with a Level 5 trauma center is a very different institution, with different costs, than a small rural or community hospital with a basic emergency room and few or no specialized services such as labor and delivery or cardiac care. This difference in intensity of care applies equally to hospital outpatient spending, which is now about half the overall spending at hospitals. A hospital that provides chemo and infusion therapies is very different than a hospital that only provides basic outpatient care.

Health Access agrees with staff that focusing on growth in hospital revenues only will ignore those hospitals with established high costs that may constitute a significant share of the spending on total medical expenditures (TME), especially in a particular geographic market[4].

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[2] "High-cost" and "outliers" are the terms used in the law.
[3] Medicare adjusts for differences in regional costs and labor costs as well as other factors that affect hospital costs.
[4] Please note: we distinguish between "geographic regions" such as the Covered California regions and "geographic markets": most or all of the Covered California regions include multiple geographic markets, if a market is defined in accordance with the 15 mile/30 minute driving time standard long-established in state regulation as the time/distance standard health plans must meet in order to have an "adequate" network as defined under the Knox-Keene Act.

Hospital Spending Measures
On inpatient hospital spending, the workgroup on hospital spending reached ready agreement on the use of Case-Mix Index to adjust inpatient hospital spending for the intensity of care provided. While Health Access remains concerned about incentives to up-code, we also recognize that different levels of care incur different levels of spending—and should. Again, a Level 5 trauma center or a burn unit or a transplant unit involves much more intensive care than a medical-surgical unit.

Health Access concurs with the members of the Health Care Affordability Board that the approach to hospital outpatient spending proposed at the last OHCA Board meeting which relied on inference from inpatient spending is not a workable approach to determine the service mix and severity of outpatient services.

Health Access continues to recommend consideration of the approach used by Medicare to measure hospital outpatient spending. We also note that DHCS uses proprietary software from 3M that adjusts for women's and children's services.[5] Health Access has a strong bias in favor of publicly available databases and models, and against propriety software. Short-term use of the proprietary software might serve as a stopgap while other parts of HCAI update outpatient hospital reporting on both financial information and services and while the HPD comes more fully online.

Categories of Hospitals
Health Access acknowledges that there are different categories of hospitals and that some though not all of the differences are appropriate to take into account for purposes of cost growth targets. Until the list of specific hospitals by category and clear definitions of the categories are provided, we are skeptical of any particular category being used in the work on cost growth targets. Our review of earlier lists of specific hospitals by category caused us to have significant doubts about the usefulness of some categories.

The discussion of hospital categories focused on individual hospitals rather than health systems. Looking at health systems is also important to this work. A critical access hospital, as designated under the federal rules, that is part of a large, profitable multi-state health system is very different than a stand-alone 20 bed hospital that is more than 50 miles from any other hospital (and usually over mountain roads).

We are also troubled that the categories are "self-designated" by the facility: if a particular category of hospitals had a lower cost growth target, then hospitals would have an incentive to redesignate themselves into the category with a higher cost growth target. We can imagine several potential solutions to this problem of self-designation, from HCAI designation based on object criteria to grandfathering as of a certain date or other options.

[5] https://www.dhcs.ca.gov/provgovpart/Documents/DRG/SFY2022-23-Medi-Cal-DRG-FAQ.pdf p. 3.

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Health Access does not support the proposed categories of hospitals and outright opposes some of them as misleading and inapt. We offer comments in the order of categories discussed in the November OHCA Board meeting:

- Critical access hospitals: Health Access supports recognition of the special role of critical access hospitals as defined in federal rules. This category includes the 38 hospitals currently designated as critical access hospitals are spread throughout California, including in Los Angeles County as well as Riverside, San Bernardino, Ventura and other large counties under federal rules.[6] These hospitals have fewer 25 beds and are more than 35 miles from another hospital.[7] We oppose a broad category of "rural" hospitals that includes very large hospitals such as Marshall in Placerville with 1,600 employees and a Level 3 Trauma Center.[8]
- Small hospitals: We have serious questions about a category made up of "small" hospitals. Staff did not provide a definition of what constitutes "small". We note that because of the post-World War II growth in the Los Angeles region, there was a proliferation of small hospitals (under 100 beds) in that region, many of which are now part of larger systems.
- Psychiatric hospitals: If the self-designation problem can be solved, it is worth considering whether these hospitals should be treated separately.
- Children's hospitals: Health Access accepts that children's hospitals play a special role in the delivery system.
- Teaching hospitals: Health Access opposes the use of "teaching" hospitals as a category. It is absurd to think that Cottage Hospital in Santa Barbara merits special consideration because of a few residencies. We would support the use of "academic medical centers" if limited to those academic medical centers providing tertiary and quaternary care, as opposed to community hospitals owned or controlled by academic health systems but providing less complicated care.
- Specialty hospitals: Health Access concurs with board members that these hospitals do not merit special consideration in terms of cost growth targets, particularly given our willingness to recognize use of Case Mix Index for inpatient spending and other measures for hospital outpatient spending.[9]
- State hospitals: These hospitals serve almost exclusively a correctional population and are often excluded from legislation that applies broadly to hospitals. Health Access would not object to excluding them entirely.
- County hospitals: It is appropriate for these hospitals to be in their own category because of the unique Medi-Cal financing of these hospitals, which involves a mix of federal and local funding sources specific to these 19 hospitals in 12 counties. Staff correctly note that local funding varies significantly by county. Health Access opposes the inclusion of hospitals in a definition of "county" hospitals any hospital operated by

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[6] https://calhospital.org/wp-content/uploads/2024/07/Critical_access_map-2024.pdf

[7] https://www.ruralhealthinfo.org/topics/critical-access-hospitals

[8] https://www.marshallmedical.org/

[9] We note that the City of Hope is the only cancer treatment center of its kind in California that is not an academic medical center. Our suggestion would be to treat City of Hope as an academic medical center for these purposes, recognizing the level of care provided there.

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the University of California which sadly fails to provide care to a significant share of the Medi-Cal population.
- “Hospitals with long average length of stay”: Further specification and definition are necessary for us to comment on this category. This phrase is not in common usage. There are various categories of hospitals that specialize in long stays, including LTACs, sub-acute and DP-NFs (as distinct from SNFs).

Summary
Health Access recommends that OHCA work with its sister agency, DMHC, as well as CDI on translating OHCA cost targets into the review of rates and appreciates the OHCA staff's inclusion of information on escalating premiums and cost sharing for consumers.

Health Access strongly supports setting lower cost growth targets for “high-cost” outlier hospitals in the top 10% or 20% of hospital inpatient and outpatient spending, measured as a percentage of Medicare, and doing so by June 1, 2025. For hospitals, the data is available, and the need to change the cost growth curve is clear. Slowing the rate of growth of hospital costs helps to meet the goal of slowing the growth of rates paid to health plans and insurers by slowing the growth of underlying claims costs, the denominator of the medical loss ratio while concomitantly slowing the growth of health plan profits and administrative costs, the numerator of the medical loss ratio. Health Access offers comments and recommendations on proposed categories of hospitals, including opposing the use of some of these categories and suggestions on revising other categories.

We look forward to working with the Health Care Affordability Board and the OHCA staff moving forward,

Sincerely,

Beth Capell, Ph.D.
Policy Consultant

Amanda McAllister-Wallner
Interim Executive Director

CC: Health Care Affordability Board
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Attachment #8

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December 4, 2024 By email: ohca@hcai.ca.gov

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Kim Johnson, Secretary-Designate California Health and Human Services board
Elizabeth Landsberg, Director Department of Health Care Access and Information
Vishael Pegany, Deputy Director Office of Health Care Affordability Department of Health and Information

Re: Follow up to August 2024 OHCA Board Meeting in Monterey County

Dear Dr. Ghaly, Ms. Johnson, Ms. Landsberg, and Mr. Pegany:

Thank you for making the effort and taking the time to visit us in Monterey County for your August 2024 Board meeting. As we sat in the audience and listened to presentations that irrefutably confirmed what we've known for so many years, that the cost of healthcare in Monterey County is out of control We feel that someone is finally listening and that you care about the workers and their families here.

Because the Board came to Monterey County, local news media has continued to spotlight the cost of healthcare and your work in Sacramento. Public pressure is beginning to move one hospital, CHOMP (Montage), toward making financial decisions and cuts that they claim will be passed on to patients within the year. The Salinas Valley Healthcare system has been publicly silent while continuing to strangle private medical practices out of existence.

We firmly believe that the August meeting presentations, consistent with our own claims experience, suggest that the three Monterey County hospitals merit a 0.1% sector target beginning in 2026. We hope that the additional deep dive into data that was mentioned in the meeting can happen quickly so as not to delay the adoption of a sector target. While we understand that there are considerable complexities in defining sectors and that OHCA would be forging new ground as the first state to do so, we hope that the extreme outlier nature of inpatient and outpatient hospital prices in Monterey County is addressed quickly by OHCA.

We greatly appreciate the hard work the OHCA Board, and its staff, are doing to bring some relief to our members who are all classified service retirees from local public schools.

On behalf of the California School Employees Association
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